Summary of New Centers for Medicare and Medicaid Services Guidelines for Medicaid Home and Community-Based Services

Note that the Centers for Medicare and Medicaid Services [CMS] issued a final rule[1] on January 16, 2014 that provides new guidelines for Medicaid-funded home and community-based services (HCBS). The rule has four key elements:

- it implements Affordable Care Act provisions that give flexibility (e.g. authorization to target specific populations, expansion of covered services) in the use of 1915(i) State Plan Amendments;
- it defines and provides explanatory detail on the requirements for providing home and community-based services funded through 1915(c) waivers or 1915(i) or 1915(j) (Community First Choice) State Plan Amendments;
- it outlines requirements for "person-centered planning" in provision of HCBS under 1915(c) and 1915(i) authorities; and
- it makes procedural improvements including:
    - permitting, but not requiring, states to combine target groups within one HCBS waiver;
    - allowing states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c); and
    - providing new standards for amendments.

With respect to the requirements for settings, CMS indicates that it is "moving away from defining home and community-based settings by 'what they are not,' and toward defining them by the nature and quality of participants' experiences." as well as focusing on "a more outcome-oriented definition . . . rather than one based solely on a setting's location, geography, or physical characteristics." The rule then establishes that any such setting must:

- be integrated in and support full access to the greater community;
- be selected by the individual from among setting options;
- ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- optimize autonomy and independence in making life choices; and
- facilitate choice regarding services and who provides the services.

The rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These standards require that:

- the individual has a lease or other legally enforceable agreement providing similar protections;

[1] *Available at:* https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

- the individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- the individual controls his/her own schedule including access to food at any time;
- the individual can have visitors at any time; and
- the setting is physically accessible.

Under the rule, a provider-owned home or community-based residential setting that seeks to modify any of the above terms must be able to identify a specific assessed need and must justify the modification in the involved individual's person-centered service plan.

The final rule specifically disallows the following settings for provision of HCBS:

- nursing facilities;
- institutions for mental disease;
- intermediate care facilities for individuals with intellectual disabilities; and
- hospitals.

Related, the rule also identifies other settings that are presumed to have institutional qualities, and do not meet the above standards. These include those:

- in a publicly or privately- owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or
- that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

States that seek to provide Medicaid HCBS in these settings will be required to justify to CMS that the settings are not institutional in nature. Any such effort must include an opportunity for public comment.

With respect to defining "person-centered planning" requirements across the section, CMS indicates that services "must be developed through a person-centered planning process that":

- addresses health and long-term services and support needs in a manner that reflects individual preferences and goals;
- is directed by the individual with long-term support needs;
- include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process;
- results in a person-centered plan with individually identified goals and preferences; and
- assists the individual in achieving personally defined outcomes in the most integrated community setting, reflecting personal preferences and choices, and contributing to the assurance of health and welfare.

The rule also establishes new requirements for amendments of HCBS waivers that involve "substantive changes". These are defined as including, but are not limited to:

- changes in eligible populations;
- constriction of service, amount, duration, or scope;
- methods and standards for setting payment rates for services; and
- other modifications as determined by the Secretary.

A state seeking to make such a change must assure CMS that it will ensure smooth transitions and minimize negative impact on affected individuals. Further, states must issue public notice and seek public input. Such amendments may only take effect on or after the date when the amendment is approved by CMS.

The rule establishes that states must adhere to the requirements of the rule as follows:

- for new 1915(c) waivers or 1915(i) state plan amendments as a condition of CMS approval; and
- for currently approved 1915(c) waivers and 1915(i) state plans, states must within a maximum of one year evaluate needs and submit a transition plan to CMS states, and adhere to the requirements during a one to five year transition plan period.